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PRENATAL CARE IN THE 1990's: ASSURING A HEALTHY START

HEARING

BEFORE THE

SUBCOMMITTEE ON GENERAL SERVICES, FEDERALISM, AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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PRENATAL CARE IN THE 1990's: ASSURING A HEALTHY START

MONDAY, MARCH 26, 1990

U.S. SENATE,
SUBCOMMITTEE ON GENERAL SERVICES,
FEDERALISM, AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Philadelphia, PA.

The Committee met, pursuant to notice, at 1:40 p.m., in Temple University Medical Hospital, Hospital Conference Center, Broad and Ontario Streets, Philadelphia, Pennsylvania, Hon. John Heinz, presiding.

Present: Senator Heinz.

Staff present: Mary E. Hayter. Minority Staff Director and Megan Hedden, Legislative Assistant.

OPENING STATEMENT OF SENATOR HEINZ

Senator HEINZ. Ladies and gentlemen, I would ask that this hearing of the Senate Government Affairs Subcommittee on General Services and Federalism come to order.

My name is Senator John Heinz. I am the ranking member of the General Services and Federalism Subcommittee of the Government Affairs Committee of the Senate.

I want to welcome all of you to our hearing, and wish you a good afternoon. At the outset I want to offer my thanks to Temple University Hospital and its community for its assistance, and, as this room testifies to, to their hospitality that has been extended to me, to my staff, to our witnesses, and to all of you in preparation for this Senate hearing.

Now, the aim of this hearing is to explore what can be done to improve the health of mothers and babies who are at risk, at risk because in our State, low income, pregnant women cannot get the help their babies need, at risk because too little is being done to prevent thousands of infants that are born each year sick and addicted to drugs.

We are going to hear this afternoon from a cross-section of Philadelphians who have experienced firsthand the obstacles that exist to receiving prenatal care, and we are going to hear from health care professionals whose daily job it is to try to deliver prenatal and neonatal care.

I have reviewed most of the testimony, all of it that has been submitted in writing, and the bottom line to the testimony all in is this: Pennsylvania's Medicaid system, as designed, fails to reach the women who need it most. It intimidates those who do apply. It

does not accommodate working women, and it is not ready to cope with today's worst threat to infant help, namely drug abuse.

In addition to many individual discussions I have been holding over the last months, and even years, just 2 weeks ago I was privileged to tour the Alma Illary Center in Pittsburgh, where I met with regional health care professionals and some maternity child health advocates.

The shortcomings of our system, or maybe "nonsystem" is a better word, were quite shocking. I learned, firsthand, the example of a young woman who lives in Butler, Pennsylvania—Butler County, and what she went through about a year ago.

What she went through is this: She is a Medicaid-eligible young woman, had never had a child before, and from early on in her pregnancy, she sought prenatal care. She knew enough that she should ask. But nothing happened, and despite repeated calls to providers, it was only after a newspaper article ran on her, and then a few days later, she was able on May 20, 1989, to get her first visit to the doctor for prenatal care, and 5 days later, she delivered a healthy baby.

For too many poor and minority women, as that case illustrates, the door to adequate prenatal care is sealed with bureaucratic red tape. Their babies pay the price. Babies born to black women in Pennsylvania die at twice the rate of White babies.

At Thomas Jefferson University Hospital, comprehensive prenatal care over 9 months costs a total of $1,900 for that 9 months period, or about $7 a day, and greatly reduces the risk of the delivery of an at-risk infant.

The cost for an average case for just 1 day of neonatal care in intensive care for an underweight infant is $2,500, for just that 1 day, for an average case, 350 times the daily cost for prenatal care, and monthly at Thomas Jefferson there are some 54 infants who receive that very expensive kind of care.

Physicians believe that a third of these neonatal, newborn cases could be avoided. Inadequate or nonexistent prenatal care and maternal drug abuse are the reasons for this neonatal tragedy. There was a study done here based on 1987 data, citywide in Philadelphia, that where the cases of some 3,139 neonatal, low-birth weight infants were examined. That study found that it cost up to $400,000 per child to take care of their needs. That was not the average; that was the worst case but that worst case translates to $1.2 billion.

For half of that amount, we could reach every pregnant woman in this city beyond the grasp of prenatal care today, according to the University of Pennsylvania and its study.

Drug and alcohol abuse, I want to say a special word about. Drug and alcohol abuse pose an especially tragic and a most rapidly growing threat to newborns. A pregnant woman that abuses alcohol, shoots heroin, or smokes crack is at very high risk of crippling her baby for life, long before that child is born.

Over the last 6 months some 1,221 babies were born here at Temple. Doctors at temple estimate that during this time, 305 of the delivering mothers abuse cocaine during their pregnancy. That is about one out of four. Tests show that at least 219 of those abuse the drug within a week of delivering.

The tragedies of crack-addicted babies here at Temple are an everyday reality in all urban hospitals, while the means of dramatically reducing this problem are available today. Support and prenatal care programs run in Pennsylvania are frankly too little, too late in helping women and their affected babies.

Solutions to problems related to lack of prenatal care, substance abuse and infant mortality, are not without cost. Those solutions are far less expensive than our way of providing care after the fact, and certainly more humane to the innocent infants who spend weeks and months in intensive care.

So, again, let me thank Temple University Hospital for allowing us to have this hearing—and let me welcome the first panel. I understand there are two who will be arriving shortly, and as they arrive if they will just come up and take their seats, we will proceed.

First, I would like to call on Tamika Robinson, who is at the table to tell us her story. Tamika, thank you very much for being here.

Ms. ROBINSON. You're welcome.

Senator HEINZ. You are very special to have gone to the time, effort and trouble to be here, and we are most appreciative of it.

And I do not want you to be nervous just because these television cameras are focusing on you, and somebody wants to take your temperature with the largest thermometer you ever saw. I apologize for that fellow—he is just doing his job.

So, please, without getting too nervous about it all, please proceed.

TESTIMONY OF TAMIKA ROBINSON, SPONSOR, HEALTH FEDERATION OF PHILADELPHIA

Ms. ROBINSON. Well, I would like to say that before I had known anything about the clinic, I was running from house to house, shelter to shelter, and I had problems finding places to eat.

I didn't know anything about the resource when I found out about the clinic. I went to prenatal care. My friends told me about the home visitor program, and how I could help, and how they could help. I was interested in the home visitor program, and after I had, you know, delivered the baby, they helped me find housing, you know, get medical cards and systems, and stuff, and——

Senator HEINZ. Do you need any help?

Ms. ROBINSON. They helped me, you know, get food from Medicaid, they came and visited when I needed somebody to talk to, you know.

Senator HEINZ. Up until the time you found them, you had been a mother before, as I understand. You have a total of 4 kids, is that right?

Ms. ROBINSON. Right.

Senator HEINZ. The first three pregnancies you did not have any help on prenatal care, is that correct?

Ms. ROBINSON. No.

Senator HEINZ. And you had not found anybody to steer you, and help you, and support you?

Ms. ROBINSON. Right.

Senator HEINZ. What difference did it make, having the help that you did get from the Federation?

Ms. ROBINSON. It made a lot of difference because I had somebody to talk to, and you know to help me with my problems.

Senator HEINZ. What was one of the tougher problems? Where did it really make a difference to have some help?

Ms. ROBINSON. To know where to go for me and my kids.

Senator HEINZ. You needed shelter?

Ms. ROBINSON. Yes. I was in a shelter, and then half of the shelters had so many drug peddlers, and people coming and taking your things, you know, and that's something I couldn't deal with.

Senator HEINZ. And they were able to find you a secure place?

Ms. ROBINSON. Well, they came and talked to me and asked me if I had any relatives, and I told them yes, so they talked to one of my aunts, and she let me come and stay there with her, you know, for a while.

Senator HEINZ. Did that make a big difference?

Ms. ROBINSON. Yes, it did, a whole lot of difference.

Senator HEINZ. Tamika, thank you very much for giving us an idea not only of what the intervention meant to you but for being an example that even if you have been through the situation several times without help, it still makes sense, and it can be tremendously beneficial to you and a mother's baby if they go and get that help, just as soon as they understand, as you did, that that help is available.

I thank you very much for that message. It is a very important message.

Ms. ROBINSON. You're welcome.

Senator HEINZ. I see that one of our other witnesses has arrived. It is Ms. Robin Loftin, I believe.

Ms. LOFTIN. Yes.

Senator HEINZ. I want to thank you for coming, and I see that you have got an additional visitor that you have brought with you, Ms. Loftin.

Would you like to introduce not only yourself but our additional witness that you have down there?

Ms. LOFTIN. This is my son. He is 4 months old.

Senator HEINZ. We want to welcome him.

Would you tell us your story?

TESTIMONY OF ROBIN LOFTIN, SPONSOR, MATERNITY CARE COALITION

Ms. LOFTIN. I am a recovering addict. I just got off of rehab. I was in a rehab for 6 months, and I have four children, and I had a bad cocaine addiction, and I never thought it would get any better and it did. I feel good about myself today.

Always before when I went into rehab, I was walking down the street, and I was praying, and I got help from the Mobility, and they were seeing me, I was crying and all, and I told them I didn't know which way to go, and they helped me get into the rehab.

Once I got into the rehab, Genesis II, I got help in prenatal care, and everything was working out, and I live in a shelter now, Mercy

Hospice, and I have to wait 1 month before I can get on a voucher program where I can get placed in a home for me and my children.

Senator HEINZ. You also at one point had a job?

Ms. LOFTIN. Yes, my first job, but I'm not able to work because the shelter doesn't have day care, and I can't afford a day care center for him.

Senator HEINZ. Tell me, from the time after you started your drug treatment, but before you had your baby, you did have a job during that period, is that right?

Ms. LOFTIN. No, after I had my baby, I had my baby in Jefferson Hospital, and then I came back to the rehab.

Senator HEINZ. Right.

Ms. LOFTIN. And I completed treatment and then I got a job.

Senator HEINZ. You got a job, and then you could not keep the job because of the lack of availability of affordable child care.

Ms. LOFTIN. Yes.

Senator HEINZ. As a result you had to give up your job.

Ms. LOFTIN. Yes.

Senator HEINZ. That is another problem that needs to be pointed out. Not only have you had a lot of difficulty, as did Tamika, finding the right kind of living environment for you and your kids, but you had gotten over for the most part your drug addiction and had done what everybody should be congratulating you on. I do congratulate you on getting a job. Because of our outdated and backward-looking laws in this State and elsewhere, you are unable to continue that job because of lack of affordable child care.

Ms. LOFTIN. Yes.

Senator HEINZ. It is a very important message that you deliver in this case to us policymakers, and I am especially grateful to you for taking the time obviously from all the other responsibilities you have for doing that.

Let me just ask you the same question that I asked Tamika, which is, of all the help you got, it sounds to me like the most important help was getting on top of your drug abuse.

Ms. LOFTIN. Yes.

Senator HEINZ. And that allowed you to put your life back together.

Ms. LOFTIN. Yes. I have hope now. Before when I was using, I never even dreamed, you know, that my life would start coming together. I am blessed, and I know that now.

Senator HEINZ. For how many years had you been a drug abuser?

Ms. LOFTIN. Eight years.

Senator HEINZ. Eight years—that is a long time.

Ms. LOFTIN. Yes, that's a long time.

Senator HEINZ. It must be a lot tougher after 8 years than after one or two?

Ms. LOFTIN. Yes. It's hard.

Senator HEINZ. To get over those problems.

Thank you very much, and congratulations.

Ms. LOFTIN. Thank you.

Senator HEINZ. We are very, very proud of you, and your little boy who looks like he is a tiger, a little sleepy tiger, but still a tiger.

[The prepared statement of Ms. Loftin follows:]

PREPARED STATEMENT OF ROBIN LOFTIN

My name is Robin Loftin. I now live at Mercy Shelter with my son. I have 5 children, 4 live with my mother in West Philadelphia. I have been in a drug treatment program since last August for cocaine use.

I first met the women from the MOM MOBILE PROJECT on the street corner last August. They were driving in my neighborhood and saw I needed help. At that time I was about 5 months pregnant and I had no place to go. I couldn't stay with my mom and I had to leave my boyfriend's because he was hitting me. They helped me find a place to stay in an emergency shelter and went with me to make sure I got into the shelter. Later they helped me get into a 9 month drug treatment program.

I recently was kicked out of my drug treatment program for breaking a house rule. I started going out with another person in treatment (movies, dinner).

I was able to find housing at Mercy Shelter. I also got my first job—a part time job—but I couldn't find any day care I could afford and had to quit my job to take care of my son. In one month I will qualify for the voucher program and have day care for my son. I hope I can get my job back then.

Senator HEINZ. I do not think our third witness, Jessica Fields, is here, is she?

[No response.]

Senator HEINZ. If not, I will tell you what we will do. We will go to our next panel of witnesses. I would like to thank Tamika Robinson and Robin Loftin for being here and telling their story. You are absolutely welcome to join us, to stay here and listen to what I am going to learn. I thank you for being here and contributing an important message, and for your gumption in coming down here and just being here.

While my trusty staff is changing the nameplates, I would like to ask our next panel, Harriet Dichter, if she is now here, Natalie Levkovich, and Dr. Donald Schwartz to please come forward.

I just want to say to Harriet Dichter I am sorry I did not have a chance to say hello to you earlier. I thank you for all your help in the preparation of this hearing, and I must say as I have read over your testimony and the other good works that you have done, I am much impressed, so we are delighted that you are here and as our lead-off witness.

I must ask all of the witnesses, however, to be indulgent and try and compress your testimony into five minutes, as a courtesy both to the other witnesses and so I will be able to keep the other appointments I have today, one of which is down at the Philadelphia Inquirer, a small struggling newspaper.

Ms. Dichter, may I ask you to please proceed.

Ms. DICHTER. Senator Heinz, if you don't mind, Donald Schwartz and I coordinated our testimony, with the understanding that he would testify first, and they refer back to each other's.

Senator HEINZ. You can do it any way you want, as long as it does not exceed an aggregate of ten minutes.

TESTIMONY OF DONALD F. SCHWARTZ, M.D., CHAIRMAN, HEALTH COMMITTEE, PHILADELPHIA CITIZENS FOR CHILDREN AND YOUTH

Dr. SCHWARTZ. Good afternoon.

I am Donald Schwartz, a pediatrician at Children's Hospital of Philadelphia, and Chairman of the Health Committee of Philadel-

phia Citizens for Children and Youth, an advocacy organization for children in Philadelphia.

I am here to speak for a few minutes about Medicaid issues which impact on the quality and nature of children's care. It is our goal, as I know it is yours, to improve health outcomes for poor pregnant women and their babies.

These hearings are being held at a time when 40 percent of Philadelphia's children and 53 percent of Pittsburgh's children are living at or below the poverty level according to a recent study by Temple University.

Further, both these cities have infant mortality rates which exceed those of the Nation as a whole and those found in many Third World countries.

This afternoon, I will not discuss the issue of outreach, follow-up, or in-home services or related social services because Harriet Dichter of the Maternity Care Coalition will speak on these issues.

Our desire is not to be repetitive, but it shouldn't be interpreted as not being supportive or concerned about these issues of access and expanded supports.

We begin by using clarity of language, of requirements, and of purpose. If this Nation is to improve the lives and health of infants, and the outcomes of pregnancy for poor women, we must develop rules, regulations, and laws which are easy to understand, which act as door-openers and not barriers.

We must design eligibility requirements which are simple, clear, and which relate to other programs of the target population. Currently, in Philadelphia some services are open to those whose incomes are at the poverty level, some for those who are at 133 percent of poverty, and still others allow participation by those whose incomes are at 185 percent of poverty.

These programs are serving the same population. We waste our time and our resources in determining different eligibilities. We also waste our children's lives.

In our Federal-state system, it is common practice for the Federal Government to establish broad guidelines for programs and for the states to exercise optional choices among these guidelines. The result has often been that the state will choose the least expensive option, reflecting concern over the fiscal impact of the program on the state budget rather than the need for the program and the impact of the choice on the citizens.

In general, this Federal-State relationship works well. In areas where there is a serious concern about an issue, however, the concern should be addressed through mandates and not options.

Thus, Congress made a decision this year that infants and children up to age 6 were so important, that health coverage up to 133 percent of poverty would be mandated. Children's lives will be saved because of that mandate. We commend that decision and urge its expansion today. We urge at the outset, that eligibility requirements for Medicaid participation be set at a mandatory level of 185 percent of poverty for pregnant women and their children.

Second, we urge that all providers, including midwives, be authorized to determine eligibility presumptively for pregnant women. This presumptive eligibility should be determined by simple rules and should extend for 6 months.

During this period, women would be able to receive prenatal care and would be able to complete registration for Medicaid.

Further, the States should be held harmless by the Health Care Financing Administration for presumptive eligibility determinations which are made in good faith.

Thirdly, in the interest of simplicity, clarity, and the health of both mother and child, we urge that all eligibility be required to last for 6 months. In Pennsylvania currently some women, the working poor, for example, are required to have their eligibility redetermined monthly. This redetermination requirement acts as a barrier reducing the chances of full participation and therefore the health chances of both mother and infant.

We urge that positive eligibility determinations continue for 6 month periods, and that all infants whose mothers were, or would have been covered, or who have no other health insurance coverage be considered presumptively eligible for the first 6 months of their lives.

During this crucial 6 month period, the mother would be able to secure postnatal check-ups and to fully register for Medicaid. More importantly, the infant will be able to receive the kind of examination, evaluation, and immunizations which will help provide the child a healthy beginning.

Recent concern nationwide about the lack of immunization and about the resurgency of diseases which we thought had been eradicated should be noted. In 1981, we thought that we had succeeded in preventing and avoiding measles in the United States. There were 1,500 cases nationwide. In 1989, the picture had changed markedly: 15,000 cases of measles were reported, including 40 deaths. This number, 40, represents the most deaths caused by measles since 1971.

Measles, polio, and whooping cough are illnesses which affect most children. They are eradicable if children are successfully immunized. Recent reports in the Philadelphia Inquirer, and I have them for your interest, document the rise in whooping cough in the city and in the Nation.

Additionally, we urge that all children up to age 18 whose family incomes don't exceed 185 percent of poverty be provided full Medicaid coverage. In this instance, again, eligibility coverage should be redetermined in 6-month periods, in as simple and obstacle free a manner as possible.

This proposal is consonant with the Waxman Bill currently in the House of Representatives and when adopted would be a major step in saving hundreds of thousands of the Nation's children.

The coverage in the end would be economical in that lives, resources, expensive hospital stays and difficult outcomes would be avoided if children could secure early care preventively.

Finally, I would like to speak for a minute or two about the problem of substance abuse, substance-exposed infants and their mothers. Others will testify about many of the issues involved in caring for this population.

In Philadelphia, Title V has been utilized to support special programs targeted toward caring for this population. The existence and availability of Title V to support creative efforts to reach preg-

nant women and children is crucial. It must be continued and hopefully expanded.

We believe there is a role for Medicaid in dealing with substance abusing or using women, and infants as well. Since the advent of the prospective payment system through the use of DRGs, that is Diagnosis Related Groups, there has been a marked effort to shorten hospital stays. This has resulted in the practice of discharging women and their newborns after 72 hours, then 48 hours, and now less than 24 hours post-delivery.

In many Philadelphia hospitals, poor women are being sent home in less than 14 hours, with apparently healthy babies. Often there is uncertainty about whether these babies will develop symptoms in the first week of life, will be able to be cared for by a woman who may have a serious drug problem, who may not have a home to go to.

In the past, longer hospital stays were used to address these social threats to children's health in order to assess better the situations and make plans for the child. This has become impossible under the current reimbursement system. We believe that a separate DRG should be created for those babies who seem to present a psycho-social risk in order that they be able to remain in the hospital for a minimum of 3 days to allow better determination of their needs and to develop a plan to respond to the needs presented.

Finally, for some of these infants who have medical needs but whose needs do not require an acute hospital stay, we urge support for a series of demonstrations or models which would encourage the development of interim placements in-home or facilities for infants and in some cases, for infants and their mothers. These models would allow infants to receive appropriate care and, where possible, would encourage the families to stay together. These demonstration programs could be supported by the Health Care Financing Administration or by a special initiative of the Medicaid program.

I thank you for the opportunity to speak with you today, and urge a continuation of expansion of benefits for infants and children. To underscore the barriers, I want to close by describing a recent experience of a patient of mine.

It involves a patient whose name is Lakita. She is a 15-year-old teenage mother. Her mother is one of the working poor. Lakita received no prenatal care because she didn't want to miss school, and all the prenatal care available in her area of the city required that she come for intake visit at 8 o'clock in the morning.

We in the program for intake mothers picked up Lakita at the time of delivery. She and her infant were entered into our program, and from that point on, we have tried to enroll Lakita's baby into the Medicaid program.

According to the current rules of Medicaid, all babies of teenage mothers should be eligible for Medicaid. This mother, at 15 years of age, skipped school and went to the welfare office here in the City of Philadelphia to enroll her baby in Medicaid. She brought the paperwork that was required and was refused 4 times because she couldn't complete the forms.

After the fourth attempt, she refused to come to us for care because it was embarrassing to her to not be able to pay for the visit. We offered her free care, and she still refused to come.

Finally, we took her to the welfare office and helped her fill out the paperwork—this is 6 months after the baby was born—and finally succeeded in getting her enrolled in Medicaid. The following month, which was at the time the baby was 7 months of age, she required another eligibility determination and was dropped from the welfare program because her mother was earning too much money, which is not the way the Medicaid eligibility is determined.

I want to use this example to urge you to realize that there are many women in Philadelphia, particularly very high-risk women, who do not receive prenatal care and whose infants do not receive adequate care, because of the needless restrictions that are placed on them through the difficult eligibility process that is required in their Medicaid, and I hope that we can change that by working together.

Thank you.

Senator HEINZ. One question. Is that a State monthly determination rule?

Dr. SCHWARTZ. Yes.

Senator HEINZ. Ms. Dichter, you are next in this one-two punch.

TESTIMONY OF HARRIET DICHTER, ESQ., CHAIRPERSON, MATERNITY CARE COALITION

Ms. DICHTER. Thank you.

Good afternoon. I'm Harriet Dichter. I am an attorney with Community Legal Services, and I am the Chair of the Maternity Care Coalition, which is an advocacy organization that also provides some direct outreach and follow-up services to low-income pregnant women and their infants.

I am pleased to discuss this afternoon some ways in which the Medicaid program can be expanded to promote better prenatal care for pregnant women. We can do more to ensure that poor women get comprehensive prenatal care. The past few years have shown a national rise in low birth weight and very low birth weight babies, following a decade in which the rate dropped substantially.

More can be done within our existing structures and programs to see that we have fewer low birth weight babies and lower infant mortality rates.

To do this, we must make the health care system respond to the needs of poor women. The Medicaid program can provide better access to prenatal care by mandating coverage of more women with fewer technical restrictions. In addition, it could also lead the way in providing comprehensive prenatal care that integrates necessary medical care with nutrition, outreach, education, and other critical support services. Expanding our ideas of comprehensive health care for poor pregnant women and infants is really a necessary part of using the Medicaid program to foster healthier pregnancies and healthier babies.

As noted in the testimony just given to you by Donald Schwartz, we are finding that when Federal law permits but does not require implementation of Medicaid initiatives to improve prenatal care,

not enough States choose to take advantage of expanded Federal options.

I will address three current State options that should be mandatory but are not.

First, it is necessary to make mandatory the option of providing coverage to pregnant women whose income is at or less than 185 percent of poverty.

Here in Pennsylvania, the Commonwealth is planning an expanded Medicaid program called Healthy Beginnings Plus, but it has not chosen to take advantage of the Federal option to cover women to 185 percent of poverty. In practical terms this means a woman in a family of three whose income is between $13,380 and $19,536 will not get coverage.

The exclusion of women to 185 percent of poverty is made even more nonsensical here in Pennsylvania because free prenatal care is given to women up to 185 percent of poverty through the Title V Maternal and Child Health Block Grant.

Second, expanding financial eligibility for Medicaid also means prohibiting states from imposing resource tests for pregnant women and infants.

Finally, we can help eliminate technical barriers and promote better prenatal care by ensuring that pregnant women retain Medicaid coverage even if their income exceeds limits during the pre- and post-natal periods. Providing complete and prenatal care costs less than 1 day in a neonatal intensive care unit. Taking away a poor woman's health insurance in the course of her pregnancy is poor public policy in a time of tragically high rates of infant mortality and low birth weight babies.

Along with removal of these three barriers to Medicaid coverage, pregnant women and children should also be able to make complete applications for Medicaid at hospitals and clinics, not just at welfare offices provided under the current law. This would begin to eliminate part of the problem that Don Schwartz just addressed. We really must eliminate this kind of bureaucratic obstacle.

The related issue of paying hospitals and clinics for care if they have made a good faith determination of Medicaid eligibility through the presumptive eligibility problem has been addressed by PCCY.

Current Federal law permits presumptive eligibility determinations. However, here in Pennsylvania with the expanded Medicaid plan, Healthy Beginnings PLus, this tells us a lot about the need for a change.

Healthy Beginnings Plus will not require its doctors and midwives to offer even presumptive eligibility. This sends the woman a message that it is acceptable to delay prenatal care while she goes through the cumbersome and lengthy Medicaid application process at the local welfare office. Yet delaying prenatal care is linked to poor birth outcomes.

Medicaid itself must broaden its scope to provide truly comprehensive care. We must all come to understand that if we define prenatal care as medical care alone out infant mortality rate problem will remain unsolved. Related and coordinated non-clinic services, including nutrition counseling, social work services, community-based outreach, and follow-up, home-based nursing services,

child-care, transportation, and parenting education are all crucial aspects of comprehensive prenatal care.

In the design of Healthy Beginnings Plus many of these services I just mentioned are included, but only as limited and discretionary services. Only clinic-based medical services are required to be offered. Further, there are no standards for determining when the discretionary services must be made available to a woman. These services are essential to improve care for low income pregnant women and should be part of every woman's prenatal package.

Whether a woman sees an outreach worker who offers her nurture and support that will assist her in obtaining adequate prenatal care, and links her with other needed services, such as food through the WIC supplemental food program, should not depend on whether the woman's medical provider understands the impact that outreach and follow-up services can have on a woman's pregnancy outcome.

All too few physicians understand that poor pregnant women require a broad array of non-clinic services as part of prenatal care. Explicit coverage of these services, in particular community-based outreach and follow-up, home-based nursing care, and nutrition/parenting education is needed, and the states should be required to offer them through the Medicaid program. Otherwise, the dangerous dichotomy that is found currently in the design of Healthy Beginnings Plus between mandatory medical services and discretionary non-medical, non-clinic services will be perpetuated. This will reduce our ability to develop effective infant mortality initiatives through the Medicaid program.

The organization I represent here today, the Maternity Care Coalition, is currently engaged in a demonstration multi-year community-based outreach and follow-up program funded in equal parts by the Robert Wood Johnson Foundation, and several local Philadelphia foundations, and the Philadelphia Department of Public Health.

Through that program trained maternity care advocates who are neighborhood women enter into ongoing relationships with pregnant women. In a largely impersonal health care system these advocates play a tremendous role. They soothe and they motivate; they make a difference in the women's lives.

To give but one example, one of MCC's maternity care advocates learned of a young woman, just 19, 5 months pregnant with her first child. This woman had come in for prenatal care once, and then it stopped. MCC's advocate went directly to her home. She arranged for a prenatal appointment and gave her the money to get there. When the woman came in for care, MCC's advocate met with her. She continued to do this at each and every clinic visit, and the woman kept her appointments. She also started coming to MCC's monthly parenting support group.

MCC's advocate also made four additional home visits as part of her effort to keep the young woman in care. The advocate provided funds for transportation for antenatal testing and other prenatal appointments, and assisted her with obtaining supplemental food through the WIC program. The advocate also became aware that the woman used drugs and helped enroll her in an outpatient program.

This woman's pregnancy ended with the birth of a healthy although slightly low birth weight baby girl, but her relationship with the advocate did not end. She is still involved with the advocate, and she regularly attends MCC's parenting support group.

Now, the intervention in this case was late. But without it the prospects for a healthy child would have been far worse. Only the maternity care advocate's regular contact and bus tokens ensured that this woman received necessary prenatal care.

The services offered by these maternity care advocates must be accessible to all women through the Medicaid program. Under Healthy Beginnings Plus, whether a woman would receive any similar services to those I described would depend on the discretion of her medical provider, and even if the discretionary services were offered, only two home visits could have been made to the young woman. She would have received no transportation money from the advocate, and she would have had access to only one parenting support group.

I urge you to take the steps necessary to permit Medicaid to enhance, and not to hinder, prenatal care.

Thank you.

Senator HEINZ. Thank you, Ms. Dichter.

Ms. DICHTER. Thank you.

Senator HEINZ. Let me reserve my questions until we hear from our third witness, Natalie Levkovich.

TESTIMONY OF NATALIE LEVKOVICH, EXECUTIVE DIRECTOR, HEALTH FEDERATION OF PHILADELPHIA

Ms. LEVKOVICH. Thank you.

Good afternoon, and thank you for inviting me. My name is Natalie Levkovich. I am Executive Director of the Health Federation of Philadelphia.

I would like to speak with you today about the Lay Home Visiting Prenatal and Postpartum Care Program. This pilot project was designed by the Health Federation, funded for a 2-year period by the William Penn Foundation and implemented at 4 Federally-funded community health centers.

Currently, the home visiting project employs 3 full-time lay home visitors and 1 nurse supervisor in each of 4 target neighborhoods. Staff provide client services during pregnancy and for 1 full year postpartum.

The Lay Home Visitors are community residents, mothers themselves, who are culturally and racially similar to the client population. They are, therefore, able to do outreach, to gain access to clients in their homes on a regular and ongoing basis, to establish a trusting relationship, to provide culturally and environmentally relevant education, to model culturally appropriate parenting, to offer support, to gather health and lifestyle information which impacts on clinical care planning, and to link clients to CHC-based primary care services.

Critical to the success of the home visitors is the careful and supportive supervision which they receive from the project nurse. The nurse supervisor provides visitors with day-to-day supervision and weekly case review. She also acts as the case coordinator, providing

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guidance for home visiting, treatment planning, integrating home visiting information into the client's medical record, facilitating client referrals for non-medical services, such as housing and education, and when needed advocating for the client.

The nurse makes postpartum home visits within 2 weeks of delivery in order to perform a physical assessment of mother and infant, to assess the home situation firsthand, and to provide teaching regarding infant care, safety and health maintenance. Finally, the nurse also has a teaching role and teaches and/or facilitates presentation of group prenatal and parenting classes.

The frequency and content of home visits varies according to a client family's level of need, as determined through a structured questionnaire and through firsthand observation. Home visits, many occurring as frequently as weekly, are supplemented with telephone contact and clinic-based contacts. Given an appropriate case mix, each home visitor is able to maintain an active case load of 40 to 50 families.

As of the end of 1989, the program had enrolled over 700 families. Of these families, I'll give you a few numbers here: 95 percent are black; 82 percent have annual incomes below $5,000; 88 percent are single; 29 percent are teens, while 42 percent are between 19 and 24 years of age; 50 percent had less than 12 years of education.

In addition to these high-risk sociodemographic characteristics, the enrolled women are also at risk by virtue of their lifestyle and obstetric history: 84 percent report the current pregnancy to be unplanned and 68 percent report being upset about the pregnancy; 41 percent report smoking cigarettes; and 31 percent drink alcohol; 28 percent self-admit to drug use; 17 percent report violence in the home.

As far as obstetrical history is concerned, 20 percent have had a miscarriage in a previous pregnancy, and 17 percent previously gave birth to a low birth-weight infant.

As you know, all of the characteristics cited are indicators of high risk for poor birth outcomes. Correlations between minority status, poverty, low level of education with the incidence of low birthweight deliveries have been well documented. Equally well known is the relationship between poor obstetrical history and risk for negative birth outcome in subsequent pregnancies. Further complications can be predicted on the basis of unwanted pregnancy and high risk maternal behaviors, such as smoking and substance abuse.

While the program has succeeded in enrolling high risk women, their birth outcomes appear to be far better than statistics would predict. For example, in 1987, based on Philadelphia Department of Public Health Vital Statistics Report, the non-white Philadelphia resident low birthweight rate was 14.8. This figure includes higher income, privately insured blacks, as well as Hispanics and Asians, groups which have been documented to have somewhat better birth outcomes than poor black women whose birthweight rate, if segregated, would be even higher.

To date, preliminary birth outcome data for our program clients reflect a low birthweight rate of about 12 percent. This is a significant decrease given the characteristics of the target population.

Other significant findings show an increase in the patient postpartum return rate, which was between 40 and 60 percent previously and which is now over 90 percent for home visiting clients. This, I would think, is a strong indication of greatly improved access and continuity.

WIC registration among perinatal patients has increased from approximately two-thirds to about 98 percent. Equally dramatic increases have occurred in the number of women attending childbirth and parenting group classes at the Community Health Centers. This, again, is another reflection of the improved motivation among clients and the degree to which they feel connected to the health care program site.

Anecdotal accounts of clients' successes in finding stable housing, establishing employment or education goals, networking with peer mothers, or even improving personal and household hygiene reflect the empowerment of clients through this intervention.

The home visiting program is a flexible, integrated and culturally sensitive model which has proven itself to be effective in delivering both intervention and prevention services to high risk families. I believe that this model could be equally effective in a variety of settings and localities. Therefore, I advocate for inclusion in this model of care in future Federal legislation and in State policy.

Thank you.

Senator HEINZ. Thank you very much, Ms. Levkovich.

I must say the three of you combined make an absolutely spectacular panel. I thank you for some very good testimony for the record. More importantly, you have given me an opportunity to ask you some questions that we need to get good answers for the record.

I am going to start with the easier questions, and let's see how it goes from there.

Two of you advocated that the Federal Government make a 185 percent of poverty level mandatory. As you know, it is optional. The State of Pennsylvania is moving to 133 percent as of the first of this coming month.

The name of this Subcommittee is the Federalism Subcommittee. The theory behind Federalism is that the State and Federal Government should work cooperatively for the benefit of our citizens. There is nothing very cooperative about a mandate. It says you will do it or else.

Why won't States cover people who clearly need the help when they are going to get, as in the case of Pennsylvania, as much as 55 percent of the bill picked up, maybe a bit more, by the Federal Government? Why do we have to tell States to do it, when it is clearly in the interests of the citizens of the State to do it? Why does it have to be the Federal Government? Why can't you tell them rather than us? After all, you're voters just like I am but I vote in the Senate, and there is the difference.

Let me start with Harriet.

Ms. DICHTER. Let me first say that I think Pennsylvania got to 100 percent initially of poverty in the Medicaid program, because advocates did in fact urge them to get to that level.

Senator HEINZ. Are you running out of steam?

Ms. DICHTER. No, I think people have been urging. I think people are still urging the State to take advantage of the option, and there are clearly fiscal issues and there are also—as I mentioned, we are fortunate in this State that for women who are not currently covered by Medicaid there are some other programs available. They are not as strong as Medicaid, but the fact is that women can get some coverage; it is not adequate coverage.

Senator HEINZ. Yes, that is all true, but I do not know that it really gets to the heart of the issue. Why can't Pennsylvania—this State has had budget surpluses more often than not. It has had tax cuts more often than not. The Federal Government has been running deficits consistently.

Now, that does not mean that we are not willing to pay. We have got a program; we are willing to pay. I have to convince my 99 other colleagues. How do I convince them that—how do I convince Lloyd Bentsen, the Chairman of the Finance Committee who was pretty unhappy about going to 133 percent? How do I convince those other people?

Ms. DICHTER. Well, I think Pennsylvania is not alone in not having gone up to 185; I believe that there may be only four States that are at 185 through the option, which I think tells us that States have not necessarily always had this as their highest priority. This is a difficult issue, there is not a readymade group of advocates out there for this issue, taking care of poor pregnant women. Poor pregnant women themselves don't often understand the connections of their bad birth outcomes to a health care system and a financing system.

Senator HEINZ. Dr. Schwartz, or Ms. Levkovich, do either of you have any answers to this question?

Dr. SCHWARTZ. I think that rather than giving a direct answer let me say that as a Federal issue, as a national issue, our country is very dependent upon a healthy population of children in order to be productive, and I think Lloyd Bentsen certainly can understand retirement and wanting his retirement supported by a healthy group of workers. And it may be——

Senator HEINZ. When you mention "retirement" to a Member of the Congress, we think of something different, but——

Dr. SCHWARTZ. Excuse me. We will all retire hopefully healthy one day.

That retirement and the security of that retirement is certainly dependent on the ability of the American workforce to be productive, and we can think of it as an investment in productivity to have those workers grow up to meet their maximum potential, and we are not doing that, I believe, unless we assure that each of them grows up healthy.

Senator HEINZ. I think you are on the right track. That is a very good suggestion. I think we need to quantify as well as, qualify the problem.

We are going to hear on the third panel about crack babies, and there is an estimate that by the year 2000 there will be 4 million teenagers who were born as crack babies. Now, that is a subset of a much larger population of, among other things, disadvantaged, at-risk children at birth—low birthweight and other problems, children with inadequate immunizations, children who get diseases at

early ages that are preventable diseases and suffer a deficit of some kind because of that.

Do you know of anybody who has the national picture on it? If not, I think we can probably find somebody, but I just wondered if any of you know of someone who can assemble the big picture and how that will impact on our workforce?

Dr. SCHWARTZ. I know that the Children's Defense Fund, for instance, puts out an annual review of the state of children in this country, which includes prenatal care, and they are very interested at the moment in both the state of the American education system and in crack babies and in what will happen with them. I think that part of the problem at the moment is that we do not have good studies of what children who were born of mothers who are crack-addicted look like when they get to be 7 and 8.

Senator HEINZ. This strikes me as something that would be ideal for Dr. Sullivan, for a variety of reasons, both where he comes from and where he hopes to go, to commission a study, with all due respect to Ms. Edelstein. She is viewed as such as strong advocate that her statistics are felt to be, at times, overly self-serving.

Marian Wright would not like to hear me say that, but that is the way advocacy organizations do operate. They paint the worst possible picture, and something is needed that is more authoritative than what comes from a single advocacy group, as intelligent and well-meaning as they may be.

So, you have given me the germ of an idea, for which I am quite grateful.

Let me ask a few specifics, if I may.

Let me ask you, Dr. Schwartz about presumptive eligibility and, why we do not have a 3- or 6-month eligibility. I was quite taken with your example of the woman Latika. What was her name, the one that you gave?

Dr. Schwartz gave, about the woman who just could not seem ever to work her way through the welfare bureaucracy. It was very alarming, as well as quite convincing.

In that instance, is there any good reason for the State to say, once you have finished these applications, it is good for 3 or 6 months? Or would the State say there really is an extraordinary sense of people who know they are going to be in clover the next day? Is there any proof of that?

Dr. SCHWARTZ. I think the way to look at it really is: what would the State lose at the moment, if the State were to allow presumptive eligibility and then continue eligibility for 6 months?

At the moment, the real stopper for the State comes from Washington because the Health Care Financing Administration will penalize the State, dollar for dollar, for any ineligible woman, for instance, who is given eligibility for a period of time, so that if the State presumes eligibility for a month it is not quite so bad but if they presume it for 6 months, or if they give eligibility for 6 months, that is a big loss to the State.

I think that that is certainly something that Washington could do to encourage states to increase the length of time of eligibility.

Senator HEINZ. Do we do that by saying that if there is a good, a one-time good faith determination, and if that is enough, or should we do something more than that?

Dr. SCHWARTZ. I think that there are two pieces to it: one is to explicitly list a set of criteria that can be used for presumptive eligibility nationwide; and, secondly, to say if those criteria are used, or if there is reason to believe that they have been used, that the State will be forgiven if a woman is ultimately found, or if a child is ultimately found to not meet those criteria.

Senator HEINZ. I last week met with three physicians representing the Pennsylvania Chapter of the *American Academy of Pediatrics*, and one of the problems they cited, among others—it was a good warm-up for this session—was the decline of participating physicians in Medicaid.

Is that a problem here?

Dr. SCHWARTZ. In Pennsylvania, actually, we are a State that does have that problem, in particular, yes.

Senator HEINZ. Where are we, and where were we? At what level of participation is there? How steep is the decline?

Dr. SCHWARTZ. I'm not going to mislead you. I don't know the particular percentages.

Senator HEINZ. Do any of you have any information on that?

Dr. SCHWARTZ. I know——

Senator HEINZ. If you could get some information on it for me, I would be most appreciative. From what you know, I assume that you have got some concerns. What are the principal disincentives for physicians? Is it all a question of reimbursement?

Dr. SCHWARTZ. Reimbursement is certainly a big part of it.

Senator HEINZ. That's the number 1, I assume?

Dr. SCHWARTZ. The recent lawsuit that Temple University brought against the State of Pennsylvania demonstrated in part how inadequate any of the reimbursement rates are within the Commonwealth.

Senator HEINZ. Now, that was a hospital reimbursement issue.

Dr. SCHWARTZ. It certainly is also reflected in provider-reimbursement.

Senator HEINZ. Can you just give us some statistics, a statistic on what reimbursement a physician gets under Medicaid versus what they might get from some other source, any kind of example?

Dr. SCHWARTZ. Let me think of what a good statistic would be: I think that one of the easier ways to look at it is cost versus reimbursement, so that in Philadelphia where I've heard that somewhere around 40 percent of ambulatory care is delivered through hospitals, hospitals receive about 37 cents on the dollar for providing primary care so that costs aren't even made, and that's according to Medicaid-allocated costs so that it is not just costs that are made up by the provider, and it is not charges.

Senator HEINZ. What you are saying is on average maybe 37 percent of costs are reimbursed?

Dr. SCHWARTZ. Yes.

Senator HEINZ. For physician, for ambulatory care, for what you would call Part B of Medicare, if you are into Medicare, and most pediatric physicians are not.

Dr. SCHWARTZ. Yes. That's right.

Senator HEINZ. What would happen, though? As you know, Medicare—not Medicaid—does reimburse, believe it or not, for pediatric services.

Dr. SCHWARTZ. Yes.

Senator HEINZ. That may seem strange to the audience, but there are people who are Medicare-eligible by virtue of a variety of circumstances who give birth; they are young people.

What would happen if we mandated Medicare-reimbursement levels for such services? Would they be adequate? Or would you like to kind of go back and review the data and let me know?

Dr. SCHWARTZ. I would certainly do better doing the data.

Senator HEINZ. Well, all right, in the interest of time and fairness, why don't we do that?

Let me ask Harriet Dichter. As I understand the goal of Healthy Beginnings Plus, and you were very good in outlining some of the concerns you had about it, the idea is to expand the scope of services available for pregnant women. I gather it is also aimed at increasing reimbursement?

Ms. DICHTER. Yes, that's correct.

Senator HEINZ. To providers as well?

Ms. DICHTER. Yes.

Senator HEINZ. Is that going to help on the problem we were just talking about?

Ms. DICHTER. I think that's right. We have a need to increase reimbursement. Some people recognize that.

Senator HEINZ. Does Healthy Beginnings Plus go far enough?

Ms. DICHTER. It's hard for me to say. Healthy Beginnings Plus certainly increases reimbursement levels above what they are now.

Senator HEINZ. Dr. Schwartz, are you familiar with what the Healthy Beginnings Plus Program does in that regard?

Dr. SCHWARTZ. I'm familiar with that the Federal guidelines say, yes.

Senator HEINZ. Well, this is the State, this is a State program.

Dr. SCHWARTZ. I think at the moment much of what is going to happen in the State remains a bit unclear to me.

Senator HEINZ. Okay.

Ms. DICHTER. I think many providers, some providers may say it goes far enough, and many providers say it does not, that the increase in rates is going to be inadequate still to take care of the population.

Senator HEINZ. One of the problems that kind of bedevils all States but is particularly obvious in Pennsylvania was testified to by our first panelist, yourselves, by the woman over in Pittsburgh that I referred to, is that we just don't come any where close to reaching the number of people that we ought to reach.

We could have the best, we could cure the reimbursement rates, and integrate the services and provide the follow-up that both of you are involved in; but if we didn't do a better job of outreach, we would still miss a vast number of people.

Should, as the pediatric physicians suggested to me last week, should we condition in some way the generous rewards that one gets from the Federal Government for being in government at the State level, based on the percentage of eligibles actually receiving services being covered?

What I am saying is if you don't do outreach and get a sufficiently large number of the needy population, should Uncle Sam instead of being a friendly old uncle become a nasty old man?

Ms. DICHTER. It's hard to address that also because you have to deal with the problem that you just addressed before, our physician participation.

Senator HEINZ. Well, I tried to make it easy by saying that——

Ms. DICHTER. You can't fix the end of it punishing the States specifically in the amount of money that they will have to allocate for services without looking at the system as a whole.

Senator HEINZ. Oh, I agree with you entirely, and that is why in my hypothetical I addressed that issue. If we cure the reimbursement, if we provide the integration of service, what do you think of, in effect, an additional mandate enforced in some way, that says if you want to get as much money as you think you deserve from the Federal Government, you have got to reach 60 or 80, or pick a percentage of the needy population, the population that is at risk here.

Is it a bad idea on the surface? Obviously, you have said there are other things that come first?

Ms. DICHTER. I think that we are very far from that. We have a long way to go in the Medicaid program.

Senator HEINZ. That's a reasonable answer.

Ms. DICHTER. Think about that, because people—we don't have the kind of Medicaid program that would even permit you to say that you have a realistic chance at this point of reaching everyone you need to reach. We don't reimburse for the kinds of support services needed to give people a chance to reach out to people.

Senator HEINZ. Now, I have got a great question for you. I told you these questions were going to get harder as we went along.

This is for Ms. Dichter.

Ms. Dichter, by virtue of a magic wand that I brought along with me, you are now John White, Secretary of Welfare, and you are in charge of the Healthy Beginnings and Healthy Beginnings Plus program, and the State Government has said to you—you can do whatever you want. I will back you up, and the Legislature is going to back me up. What are the first three things you would do?

Ms. DICHTER. Well, I think actually I have addressed in my testimony the kinds of things that I believe need to be done.

Senator HEINZ. Okay, and those can all be done by, in effect, the Secretary of Welfare, if he or she is backed up?

Ms. DICHTER. I think so.

Senator HEINZ. Okay, that answers the question.

Let me ask Natalie Levkovich—I listened with interest to your Lay Home Visiting program. I also listened to what sounded a little bit similar, the Maternity Care Advocate program, the Maternity Care Coalition is involved with—and, by the way, for the record, I would like to point out that our first witness, Tamika Robinson, was accompanied by two women who are involved in your program, is that right?

Ms. LEVKOVICH. That is correct.

Senator HEINZ. I should have introduced them. Do you happen to know their——

Ms. LEVKOVICH. They are gone now.

Senator HEINZ. They are gone.

Ms. LEVKOVICH. Sonia Porter and Yvonne Moore, yes.

Senator HEINZ. Thank you for putting them on the record. They were in the back, and I should have introduced them.

How similar are these two programs? In what ways are they different?

Ms. LEVKOVICH. Well, I can better address the features of the Health Federation's program, as I think they are unique, rather than comparing the two.

One of the things that stands out in our program is the longevity of contact. Home visits as often as once a week, sometimes less frequently than that, but no less frequently than once a month, are provided throughout the prenatal period and for a full year postpartum.

What happens in the home is the kind of informal education and psycho-social support which enables women to take care of the services that are available. The home visitors in our program are the employees of the health care-provider agency, so it is not a referral; it is rather an inherent part of the medical services.

The home visitors are employees of the Community Health Center; they see the patients in the home; they see the same faces in the childbirth education class, in the prenatal session waiting room. The home visitors communicate directly with the medical providers so that it becomes really a systemic part of the service, as opposed to a referral and advocacy service.

Senator HEINZ. You know this, the idea of home visitation is kind of a new idea that is very old whose time has reappeared.

Ms. LEVKOVICH. Yes.

Senator HEINZ. In the mid-nineteenth century, it was a very important part of our health care delivery system.

What do we know about the cost effectiveness of this approach?

Ms. LEVKOVICH. Well, we have not completed a final evaluation of the pilot project. However, that will be available in the fall.

So far, the preliminary data, with just the decrease in the low birthweight rate for our population, given the statistics, the cost figures that you quoted for the care of low birthweight babies, if we are successful in, continue to be successful in reducing the number of low birthrate babies, then just this handful will have paid for the program.

The cost of the program per family, and remember that the family benefits not only the mother but a number of offspring, so you could divide this number by the number of individual beneficiaries, but the cost of the program is approximately $1,000 per family, which is equivalent to half a day in intensive care.

So, it doesn't take many prevented hospital days to pay for the service. There are other issues besides prevention of low birthweight, such as the number of families who have been helped to plan for a return to work or education, who therefore will have a reduced need for a variety of publicly funded social services.

The improved parenting and bonding relationship within the family that avoids abuse and neglect issues, a lot of that is hard to calculate; and, as you know, prevention is often hard to document.

But even if we rely only on the concrete figures related to avoided hospitalization, I think we will successfully demonstrate that this program is for free.

Senator HEINZ. What can be done at either the Federal or the State level to encourage more of that?

Ms. LEVKOVICH. Well, I think that there are model programs such as this one, and variations on this theme that have been documented to be effective, but they have been funded as demonstrations or they have been funded through private philanthropic source on a time-limited basis; and it seems to me that the inclusion of such proven programs, such proven services in the development of reimbursement and public policy, as opposed to the funding of new models and new experiments would certainly be helpful.

The provision of this service is not difficult, only financing it is difficult.

Senator HEINZ. Is there reimbursement for it?

Ms. LEVKOVICH. There is none.

Senator HEINZ. Is it covered at all?

Ms. LEVKOVICH. There is none.

Senator HEINZ. There is none.

Ms. LEVKOVICH. Zero.

Senator HEINZ. None, either Federally provided for at State option, or——

Ms. LEVKOVICH. No.

Senator HEINZ [continuing]. In any State program?

Ms. LEVKOVICH. No.

Ms. DICHTER. Actually, theoretically a State could probably request coverage, possibly request coverage for this under Medicaid. It would probably be very difficult to get it approved.

Senator HEINZ. Well, I look forward to having your study this fall. I hope you will mail me a copy for a lot of reasons.

Ms. LEVKOVICH. Indeed.

Senator HEINZ. What you are saying, I gather, is that Healthy Beginnings Plus is not in a position to recognize the value of home visitation, is that right?

Ms. DICHTER. Actually, I tried to point out, Healthy Beginnings Plus will cover a very small number of home visits on an optional basis, provider optional basis.

Senator HEINZ. Yes, up to two.

Ms. DICHTER. Up to two.

Ms. LEVKOVICH. But that is very different than the kind of relationship building and long-term follow-up that is inherent in this program. The home visitation in the Healthy Beginnings Plus scenario is nurse home visit for medically high-risk patients and homemaker services to help with household chores, again for medically high-risk patients. It doesn't address psycho-socially high-risk patients at all.

Ms. DICHTER. It does provide for a total of a few home visits that relate to neither case finder who missed appointments; the point is they are discretionary, and, as Natalie has so eloquently described, they are not systems built in; it is not incorporating what really helps to keep women into care, into a system of care at all, by any stretch of the imagination.

Senator HEINZ. It sounds like, Dr. Schwartz, it would really have been a good idea for Lakita to have had access to that kind of support.

Dr. SCHWARTZ. I think that Lakita would certainly be considered at high risk because she is a teenage mother. Her particular problem is more related to eligibility concerns than it was the home visitation. We, in fact, visited her at home and took her to the welfare office, and were marginally successful because of the difficulty of getting straight the eligibility requirements.

Senator HEINZ. But I understood she went down there four times.

Dr. SCHWARTZ. Yes.

Senator HEINZ. And kind of could not handle the paperwork, and I guess—I don't know how long that took, but you indicated it took 6 months——

Dr. SCHWARTZ. That's correct.

Senator HEINZ [continuing]. Before she ever got plugged in. Had there been someone working with her, I gather, she would have had a much better chance of having gotten her eligibility on her first visit to the welfare office?

Dr. SCHWARTZ. I certainly believe that.

Senator HEINZ. One question: If any of us were in fact eligible and we went down to the welfare office and we got our forms right the first time, how long would it be before we got our eligibility and our care, or whatever it took so I could go to you?

Dr. SCHWARTZ. It's usually a month to 6 weeks.

Senator HEINZ. A month or 6 weeks. So whatever it takes, it's a month or 6 weeks in addition?

Dr. SCHWARTZ. Yes.

Ms. DICHTER. The law provides, I believe, for the State to determine eligibility within 15 days of a completed application.

Senator HEINZ. It can, or it must?

Ms. DICHTER. Within 15 days of a completed application, that is a term of art, "completed application," there needs to be an eligibility determination. But Dr. Schwartz is right, it takes a tremendously——

Dr. SCHWARTZ. To get the card.

Ms. DICHTER [continuing]. Long amount of time to get Medicaid coverage or any kind of welfare coverage.

Dr. SCHWARTZ. Right.

Senator HEINZ. Well, I think you have been extraordinarily helpful, and most insightful, and I appreciate your answers to all my questions, easy and hard. I hope I really did not ask you any easy ones.

Thank you very much for being a part of our hearing.

Ms. DICHTER. Thank you.

Senator HEINZ. I'd like to ask our next and last panel to come forward.

Dr. Hallam Hurt and Ms. Teresa Ann Hagan.

Thank you, both, very much for being here. Dr. Hagan, you are the Chairman of the Division of Neonatology at Albert Einstein; Ms. Hagan, you are the Program Director of the Family Center at Thomas Jefferson. Is that right?

Ms. HAGAN. Yes.

Senator HEINZ. Let me ask Dr. Hurt to go first.

Dr. Hurt.

TESTIMONY OF HALLAM HURT, M.D., CHAIRMAN, DIVISION OF NEONATOLOGY, ALBERT EINSTEIN MEDICAL CENTER

Dr. HURT. Well, I think first I want to know if you are going to have that magic wand left for the problem that I am going to be talking about, because I think we need one.

I was asked to talk about the drug problem in the city and its effect on prenatal care, and what I would like to do is just take you through some of the data that we have in the city, and despite the fact that I think it is very impressive some of these innovative programs that are described, I feel myself, and also from some of the data that we have, that an overwhelming problem in getting prenatal care is heavily related to drug use, and I'll try to explain that.

Senator HEINZ. Okay.

Dr. HURT. About this time last year, the city and the medical professionals in the city were concerned about the drug problem, and on a joint venture, the Philadelphia Perinatal Society and the Philadelphia Department of Public Health looked at 1,000 births in Philadelphia to see what the incidence of maternal cocaine use, what happened to these babies.

And the result of that study showed that in the city about 17 percent of women admitted to using cocaine, we feel it is probably more like 20 to 22 percent, so that is 1 in 5 women delivering in eight city hospitals use cocaine: 88 percent were black among the cocaine users versus 68 percent in the non-users; 83 percent were on medical assistance versus 58 percent of the non-users.

But what we are talking about today was just an extraordinarily dramatic statistic, and that was that 71 percent of the drug using women had no or poor prenatal care versus 15 percent of the non-users.

So I think that despite this difficulty in getting into the care system, at least in this particular study 85 percent of the non-drug-using women got five or more visits, as far as prenatal care.

The babies born to the women who used drugs were smaller, born earlier, had longer hospitalizations: 1 in 10 went to foster care. And of those babies, as you have already heard today, 30 percent went to intensive care nurseries versus 10 percent in the non-drug-using women.

So, we were really startled by this lack of prenatal care. But one of the confusing things in the study is that not every patient was on medical assistance, so one has to wonder, are there barriers from low socioeconomic status that are not experienced by women who do have private insurance; and we have discussed that already today.

So, in our own institution at Albert Einstein, we have a study that is in progress in which we have matched women for low socioeconomic status, so we are trying to take out that factor, and we are looking at whether or not they have the same outcome in pregnancy. So, we have 52 mother-infant pairs that are divided into cocaine-using women and non-cocaine-using women.

Interestingly, again, there essentially is 70 percent of the cocaine-using women have no or poor prenatal care versus 25 percent of the women who do not use cocaine but are of low socioeconomic

status. It's highly significant statistically, but it looks as if there is a drug effect, not related to just being poor.

In addition to that, 60 percent of the cocaine-using women, when they come to the delivery room, have already ruptured their bag of waters, meaning that this may have been, as we know, it could have been hours, days, that they do not come in for delivery, and that is versus 25 percent of non-cocaine-using women.

And, as we know, all too well, in recent months, sexually-transmitted diseases are markedly increased; 40 percent of the cocaine-using women had sexually-transmitted disease during their pregnancy versus 16 percent.

So we feel that the drug issue on them, regardless of low socio-economic status, the drug issue seems to be a very, very powerful influence on women's lack of attention to themselves and to the fetus.

We have also, many of us, and I am sure you have heard, wondered what has happened to the baby after it's born. There is apparently gross inattention during pregnancy. What about the baby after delivery?

And, again, in a study at Albert Einstein, looking at 50 cocaine-using women and 50 non-cocaine-using women, we looked at how often they visit their baby if the baby is in the intensive care nursery; and, after a week of hospitalization, we look to see the number of women who would visit or call once a day, or more. Six out of 10 women who didn't use drugs would make that visit or call at least once a day, but only 3 out of 10 of the cocaine-using women did this.

In addition, at our institution essentially 1 in 5 of the infants of the cocaine-using women were placed in foster care versus about 1 in 50 in the control group.

So what I think we have before us, at least in this city is a woeful lack of prenatal care. Certainly 15 percent is far too much even in non-drug-use women, but I think with the use of crack that we see an imitation to pregnancy, oneself, and to the baby after delivery.

Senator HEINZ. I think your statistics prove that conclusively, and are extremely dramatic.

Am I right in understanding that you are doing a follow-up study?

Dr. HURT. Yes.

Senator HEINZ. To your initial study?

Dr. HURT. Yes. We have at this point, at our own institution, we are continuing to enroll mothers and babies, and we are looking at their neodevelopmental outcome. We are looking at whether or not they did get immunizations. We are looking at how many had sudden infant death. But I think our numbers are too small to make any judgment.

I'll just add one thing I didn't mention, but in our follow-up study we make monthly phone calls to try and make sure these moms get in with their babies, et cetera, and in the cocaines, 40 percent of the contacts are with the non-biological mom, and that's versus, I think it's about 16 percent, yes, of the control moms, the non-biological mothers.

So, again, it looks as if this inattention continues, and I think we all have our war stories, and case examples are dramatic, but I think these figures speak for themselves. Until by trying to decrease infant mortality and improve prenatal care, I think all the programs in the world in this city will make some inroads, but they won't be nearly complete enough until we handle this problem.

Senator HEINZ. Dr. Hurt, I have some questions for you, but I would like to ask Teresa Ann Hagan for her testimony.

TESTIMONY OF TERESA ANN HAGAN, PROGRAM DIRECTOR, FAMILY CENTER, THOMAS JEFFERSON UNIVERSITY HOSPITAL

Ms. HAGAN. Yes. Thank you for asking me to speak to you today.

I am the Program Director for Family Center, Thomas Jefferson University Hospital.

Family Center is an outpatient voluntary program designed to provide intensive medical and psychosocial services to drug and alcohol dependent women who are pregnant. This multimodality treatment program endeavors to facilitate the best possible physical, psychological, and sociological outcomes for both mothers and infants.

Comprehensive medical services at Family Center include a prenatal clinic which is staffed by obstetricians specifically trained in the field of addiction and high risk pregnancy. Infants exhibiting withdrawal are treated in the newborn nursery by our neonatal physicians.

A wide range of psychosocial services are offered. Those services are comprised of two components: education and treatment. The educational focus targets prenatal and parenting classes, as well as AIDS-prevential counseling. Treatment aims are directed at developing personal resources, improving family and interpersonal relationships, reducing and eliminating socially destructive behavior, and facilitating the parental/child bond.

Over the last 20 years of operation, we have found that we can rehabilitate a significant number of women who have come to us during pregnancy. Moreover, in methadone-maintained women, we have been able to reduce the incidence of the low birthweight infants from nearly 50 percent to 18 percent.

This reduction is significant in terms of medical costs. Presently, a 2-pound infant will accrue medical expenses totaling approximately $150,000.

Research at Family Center has resulted in successful treatment protocols for infants undergoing withdrawal. Our long-term studies indicate that the provision of perinatal services to this very high-risk population results in infants and children who are physically, neurologically, and developmentally normal.

Family Center also recognizes that addiction is more than a medical issue. The women are weakened by unemployment, illiteracy, homelessness, and legal issues. Presently, 10 percent of the women and their children are homeless. Well over 50 percent experience periodic problems with housing. Other social problems include illiteracy, crime, unemployment, and diseases associated with IV drug use and poverty.

Our research demonstrates that many environmental variables contribute to addictive behaviors. For instance, one Family Center study compared drug-addicted and non-addicted women from similar socioeconomic backgrounds. There were significant differences in the following areas:

Nearly 70 percent of the drug-dependent women experienced early sexual abuse, and that is before the age of 16. In the non-addicted women, 15 percent had been abused sexually; 83 percent of the drug-dependent women had a chemically-dependent parent; 75 percent of those parents were alcoholic. In contrast, 35 percent of the non-addicted women had a chemically-addicted parent. The families of the drug-dependent women had higher levels of family conflict, physical violence, and lower levels of familial cohesion.

Treatment must respond to each and every one of the medical and social variables which complicate addiction and recovery. For instance, while methadone may encourage a heroin-free existence, and assists in the provision of healthier infants, it does not answer the social problems faced by the Family Center woman. Relapse is imminent when daily survival is at risk.

Our cocaine-dependent pregnant mothers present us with corresponding complex social ills, as well as the same kinds of medical problems we used to see in the heroin population, prior to methadone, abruptio placentae, stillbirths, decreased infant birthweight, decreased infant head circumference and length.

Drug addiction is a debilitating disease due to its chronicity and intermittent relapses. Moreover, with regard to children, it has long-range and intergenerational implications. It is even more devastating to drug-dependent women and mothers who so frequently do not have the resources for recovery available to them.

The words of one of our patients, a 35-year-old white woman with three children who was physically and sexually abused as a child and who subsequent to her mother's death at 15 began to use psychoactive drugs are most relevant. She says:

"Drug-addicted mothers love their children just like any other mother. I love my children, but it's not easy to stop using drugs. Treatment has helped me to recognize how my background has influenced my addiction. I medicated my pain for a very long time. Now, I can talk about this pain and face it without running away."

Because of the lack of treatment services and research endeavors within the drug-addicted population, we are now plagued with rampant drug addiction. Because of the intergenerational transmission of the disease of addiction, as a country, we have fostered a spiraling legacy of addicts giving birth to addicts.

This stark reality has now developed into the fact that soon many thousands of babies will die of AIDS. If only 10 percent of the resources for treatment and research provided for such conditions as cancer, heart disease and stroke had been applied to this population several decades ago, we would not have the overwhelming problem of rampant addiction.

As a result, we have the tragedy of babies that are handicapped not only because of their premature birth, potential for congenital malformations, and the development of AIDS, but also for their exposure to devastating social environments.

We have had a drug abuse epidemic for a quarter of a century and, due to the lack of the resources for treatment, research and education as well as the lack of interest by professionals, we have not provided effective solutions.

Children are suffering due to our previous unwillingness to act with urgency. We must remove the barriers to prevention, intervention, and treatment of drug-dependent mothers and their children.

Family Center has two decades of treatment and research experience with this very high-risk and needy population of mothers and infants. We, therefore, recommend the following:

First, and utmost, we think there is an urgent need to expand the availability of methadone to pregnant and postpartum women who are intravenous heroin abusers. This must be coupled with comprehensive treatment services. Appropriate surveillance within programs treating these women is essential in order to monitor them and to give them appropriate public health advice with regard to the human immunodeficiency virus. Caring professionals who are also knowledgeable in the field of substance abuse must put the treatment of women in the context of their reality.

Secondly, due to the complications associated with addiction, our energies with regard to treatment and prevention must have as a priority, housing, and education. The Family Center has obtained the funding for a building and staff to initiate residential treatment for 50 cocaine-addicted women and their children. We have designed a residential program which would provide intensive drug and medical treatment, as well as an extensive educational and job training component. This would allow us to address the significant issues of housing, education, job training and family dysfunction in drug-dependent pregnant women.

In addition, we will be able to influence the development and socialization of their children. This kind of project could serve to eliminate the medical and the social problems experienced by the drug-dependent woman and her children, particularly those that are cocaine-dependent and for whom there is no pharmacotherapeutic agent such as methadone.

Appropriate services for the follow-up of these pregnant women are essential. And, finally, the issue of abandonment of the children and foster care needs must be addressed and planned appropriately. It is the very least that we must do so that we can be assured that future children will not be plagued by the pain and suffering of drug addiction.

Senator HEINZ. Thank you very much, Ms. Hagan. That is a very eloquent as well as persuasive statement, a lot of meat on the bones.

Let me start by asking Dr. Hurt, if it is true there are a lot of crack babies that aren't being identified? Is it fairly simple to do something about that, to improve our identification of newborns who are exposed to crack or other illegal drugs?

Dr. HURT. Well, I think probably—well, we may underestimate it if we just use mother's report by 25 percent, and the only way you could really do that would be by mandatory screening.

Senator HEINZ. Should we do that?

Dr. HURT. Well, I'm not a lawyer, but I don't know. I think that at this point it does make a difference to know whether or not the mother is a drug user, and if the mother denies it but we suspect it because of sexually-transmitted disease or poor prenatal care, we test the baby anyway.

So, as to whether or not there should be mandatory screening, I think we obviously screen for syphilis, and we don't screen for HIV. This is somewhere inbetween.

I think that it may or may not drive mothers away from prenatal care. That's a major fear.

Senator HEINZ. In Pennsylvania is there a requirement on what tests hospitals are required to do on newborns?

Dr. HURT. Just—well, no. There is the routine screening for PKU and hypothyroidism, but there is not screening for other diseases. Mothers are screened for the presence of syphilis, but not HIV, and not drugs.

Senator HEINZ. But do all hospitals in Pennsylvania screen the newborns for drugs?

Dr. HURT. I think it depends on the level of awareness in the particular institution, and I think most hospitals that deal with this routinely pretty much do what I said, that even if the mother denies it but that they suspect it in the baby, they will screen the baby's urine for cocaine.

Senator HEINZ. One of the questions, and I really address this one to both of you. Where I sense we do not have as much research as we would like, but some indications are, that if one does find an infant that is born to a cocaine or crack-addicted mother, that intervention with the infant is important, and will provide certain health benefits that are very important to that infant.

Is that true? If so, what kind of research information, outcomes, knowledge do we have?

Dr. HURT. Well, I think it definitely is true, and Terry certainly commented. I think there is no question but that the social issues need to be addressed. Whether or not these children are going to truly have increased medical problems, you know, are they going to truly have increased brain abnormalities because of cocaine, that is not entirely clear yet.

There is absolutely no question that in this city they go home to poverty, to venereal disease, and to known drug abuse, and I think that the problems that we discussed early, about early discharge, are left in the hospital's lap. In my institution, we don't send the baby home until there is a social service consult in the well-baby nursery. However, that cost is passed on to the hospital.

So that's something that I thought that there were some good suggestions about that, that would definitely help.

Senator HEINZ. So, one of the reasons, if you will, for the kind of at-risk infant 3-day DRG is to permit——

Dr. HURT. Absolutely.

Senator HEINZ [continuing]. If you will, a kind of, some research and support into the home——

Dr. HURT. There is no question.

Senator HEINZ [continuing]. Generally.

Dr. HURT. That is absolutely for certain that that is a major difficulty, and the other medical problems, as things begin to get sorted

out, it may turn out that all these children need certain x-rays, you know, certain blood studies, screening for other infectious diseases that could be critical medically.

We obviously know that essentially 30–35 percent infants of drug-using women are admitted to ICNs for this 10 percent of non-drug-using. So, they do have more medical problems, but I think those may be related to problems in pregnancy, and not that the baby has a congenital heart malformation.

Senator HEINZ. So, the answer is that where you have a child that is born to a drug-dependent mother, it is important to know it.

Dr. HURT. Yes.

Senator HEINZ. But the reason to know, and the value of knowing, is related to being able to intervene at the home or in the neighborhood. It is not so much, insofar as we know, a physiological question, if possible then.

Dr. HURT. Well, that's highly controversial, and I think that at least at Albert Einstein we do look at them for other medical problems. There is just not a whole, crystal-clear——

Senator HEINZ. There is not a lot known.

Dr. HURT. Right. There are a lot of suggestions, and the neurobehavioral, how smart is the baby going to be—those questions that have the educators just terrified may all turn out to be true. We know these babies are smaller than their cohorts, their heads are smaller, and early information is that their IQ may be the same as others but that they are different behaviorally, they are not interested in their environment, they are not creative.

And, as I said, the educators are terrified that these children are going to descend on the public education system.

Senator HEINZ. Let me ask Ms. Hagan about that.

Ms. HAGAN. What is interesting to us about those studies, there are many other confounding variables, and they are not controlled for. In other words, alcohol use, diazepam use. We know what happens to a woman when she does not have prenatal care. We know what happens to a woman when she doesn't get the proper nutrition, and what happens to that infant.

And not one of the studies controls for those. Some of the studies control for environmental factors, but I am not very satisfied with those, and when you send a child home to the kind of dysfunctional familial situation, you are bound to get some of the kinds of behaviors that we are seeing.

I would also like to add that we have known about fetal alcohol effects for a very long time, and the kinds of hyperactivity that we see or that we are hearing about in these cocaine children could possibly be related to that as well.

Senator HEINZ. We read in the newspapers about crack mothers who are disadvantaged, often black, live in large urban centers, how much is known about crack-abusing women living typically—White, urban, middle-class neighborhoods?

Ms. HAGAN. Well, that is a wonderful question. We had a medical student at Jefferson this summer who asked that very question, after the 1,000-baby study, and did some urine screens on babies that were born, I believe it was in July, at Thomas Jefferson. Of 50 percent of the births that were related to cocaine, we found that 14.6 percent of the births there in that month were cocaine-related;

and 50 percent of them came from private pay, and 50 percent came from medical assistance.

Senator HEINZ. That is quite surprising.

Ms. HAGAN. That's absolutely astounding, and the worry is that the women—and when you talk about drug-screening, I would want to ask you, are you also willing to screen the middle and upper middle class women? Because this becomes an issue; it becomes a class issue.

Senator HEINZ. Well, my question to Dr. Hurt was, all children, not Medicaid-eligible, not Black, not poor—but my question there was all children.

Dr. HURT. No, I agree completely. There is a tremendous double standard because if one of these private patients came in and had cocaine in her urine, you wouldn't think about taking that child to foster care; and I think that it is a major, sort of double standard.

Senator HEINZ. And also it is an invisible problem.

Dr. HURT. Yes.

Senator HEINZ. A hidden issue.

Ms. HAGAN. And interestingly, we also know that some of the variables that I described, certainly not the poverty variables but when you look at the tendency toward severity of addiction and length of addiction, you begin to look at the background variables that I described around sexual abuse, and certainly poverty is one of them for some groups, but even in the middle class, we also see sexual abuse. We see alcoholism in the backgrounds, and many times these women aren't getting the treatment that they need because they are not being confronted by obstetricians who are saying: "You have a problem."

Senator HEINZ. Earlier I mentioned the U.S. Department of Health and Human Services Inspector General estimates we will have by the year 2000 4 million teenagers who were born as crack babies.

What are the implications of that? What do we know about their basic endowment which you started talking about a little, Dr. Hurt? They may have the same IQ, but they may be wired differently is what I heard you saying.

Dr. HURT. Well, again, I think we are reading the same studies. I have the same concerns that Terry does about the problem.

Senator HEINZ. What are the implications for our schools, or for our workforce?

Ms. HAGAN. We need about 1,000 cocaine-baby study over a long period of time.

Senator HEINZ. Any informed guesses?

Dr. HURT. Well, it cannot be good to have a smaller head than somebody else. You know you have to—the way the drug works, and it works on neurochemicals in the brain, that it—well, it can't be good. I think that we are giving you, I believe, a very careful, understated—perhaps we should be a little more provocative—assessment, that we just don't know.

But the early studies are that there are going to be behavioral changes perhaps, but whether or not they are not going to be smart, I don't think we know.

Ms. HAGAN. Well, and you also need to be careful about the head size in relation to the body size, and a lot of studies aren't giving

you the body size, and certainly we know that these are smaller infants. So, one really needs to read these studies very, very carefully.

I am much more concerned, if you ask about those 4 million children, I am much more concerned about the environment that they live in at this point. I personally think that the cocaine addiction is just a scab on top of a much larger social cancer.

Senator HEINZ. I think the statistics that Dr. Hurt cited about the background of sexual abuse and alcohol abuse in the families of the women who came in and were addicts and did give birth to drug-addicted children are very instructive in that regard, and that, if you will, the actionability from what is being learned is to go back and do the best that you can with the environment that the child is going to go back into.

Dr. HURT. One thing that hasn't been mentioned is the question of deaths in these children, and we talk about neurodevelopmental disability, and there has been a number of studies suggesting that these children have a higher incidence of crib deaths. And, again, I personally feel that there is no question that more of these children in the drug families die after they go home, whether or not it's card-carrying crib death or CIDS, I don't know, but there is certainly in our experience, and in the literature, there is no question that they not only go home to this drug-abuse environment, but that more of them die.

And I think that is one of the things when you go back to your colleagues that from our standpoint what we keep coming back to, you know, what can you tell these people to make them give more money for these preventive programs—is that it is not the baby's fault. And these children, by the luck of the draw, are born into this situation, and we, by the luck of the draw, weren't, and it just seems as if the only fair thing to do is to give them the best chance possible, which is going to involve a lot of money.

Senator HEINZ. To return to one of the earlier themes in the hearing, which was the bureaucracy and red tape and Catch-22's that we impose to make what little in the way of help and services that are available even less available than they are, I understand in New York City about half of the drug treatment programs refused to admit pregnant women. I also understand about two-thirds of those same drug treatment programs denied treatment to pregnant women who also happen to be on Medicaid.

I know that, for example, we here in Pennsylvania have a restriction on receiving two Medicaid services in the same day.

Is that a Catch-22 that catches some of the people who need help? Or are there other—and/or are there other Catch-22s?

Ms. HAGAN. Well, in the incidence of not paying for two services in 1 day, if we have a woman who comes in to receive Methadone medication, and she needs to have counseling services that same day, we are only paid for one service and not for both services.

Senator HEINZ. Will you provide those services?

Ms. HAGAN. We don't deny—absolutely, we provide both services, and we provide a lot more services than we are ever paid for; but one of the reasons we have been able to do that is because we generate research moneys which helps to subsidize that. In essence, we

are helping to subsidize MA, to provide the kind of treatment that we do.

Senator HEINZ. Would there be somebody who would come to do for a Medicaid-reimbursed service that also would have to elsewhere for a Medicaid service, or do you provide everything, virtually everything anyone might expect?

Ms. HAGAN. Yes.

Senator HEINZ. I am thinking child care is a Medicaid service, for many people. But if you are—how does that work? Can you not get child care and health care on the same day? How does that work?

Ms. HAGAN. Well, we do not provide child care at this point. We will through this residential treatment program provide that, and we will certainly have to be providing some on an outpatient basis.

As far as I know, I don't want to commit myself to saying whether we would be paid for drug and alcohol and child care because I don't know the answer to that.

Senator HEINZ. Fair enough.

Is there any other point you would like to make for the record, because I have found this very, very useful.

Yes, Dr. Hurt?

Dr. HURT. Just one thing. I think looking at the prenatal care problem that I think there are some individual studies in the city, and certainly again maybe the Philadelphia Perinatal Society in the city would like to look at, why is it that they don't come? We may think we know, but maybe we should ask the people who don't come.

Is it overcrowded? Is it the paperwork? Or is it that they are afraid of having the baby taken away? I have had people who are afraid their MA check is going to be taken, and they are afraid they are going to go to jail.

So, maybe, if we ask them, first of all, why they didn't come and what on earth if anything would make them come, then maybe we would have something really to work with, in order to get them into the system, because I think that I hear people talk but if we don't have—if we have 1,000 mothers that we could ask this question, why didn't you come? and what would make you come? then maybe we would be able to give you some more definite information about how to attack the problems.

Senator HEINZ. Does that mean your next study should be 2000?

Dr. HURT. Our hope is before the year 2000, but yes I don't know. I think that certainly is something that the Philadelphia Prenatal Society voted on last week that they would like to explore that with this city, and so the city is eager to do that. So maybe then we will have a handle because I don't know why they don't come, and we think it is also just the addiction to the drug; they just don't care.

Senator HEINZ. Yes.

Well, thank you, both, very, very much. I appreciate your help and that of all our other witnesses; it has been extremely valuable.

Our Subcommittee is adjourned.

[Whereupon, at 3:30 p.m., the Subcommittee adjourned.]

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